PRINTED: 08/18/2009 FORM APPROVED

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		NVS640HOS		B. WING		08/1	4/2009	
NAME OF PROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
MOUNTAINVIEW HOSPITAL			3100 N TENAYA LAS VEGAS, NV 89128					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATIC			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
S 000	0 Initial Comments			S 000				
	This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 08/14/09 and finalized on 08/14/09, in accordance with Nevada Administrative Code, Chapter 449, Hospitals.  Complaint #NV00022015 was substantiated with deficiencies cited. (See Tags S0035, S0050, S0300, S0310)  Complaint #NV00022187 was unsubstantiated.  A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included.							
	Monitoring visits may on-going compliance requirements.	be imposed to ensure with regulatory						
	by the Health Division prohibiting any crimin actions or other claim	clusions of any investign shall not be construed all or civil investigations for relief that may be under applicable feder	d as s,					
S 035	NAC 449.313 Governing Body			S 035				
	workable set of bylav and available to all m body shall. (e) Ensure that the m the governing body for the medical staff prov	dy of a hospital shall ad vs which must be in write dembers. The governing dedical staff is accountate or the quality of care whe vides to patients of met as evidenced by	ting 3 ble to nich					

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 08/18/2009 FORM APPROVED

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER:

NVS640HOS

STREET ADDRESS, CITY, STATE, ZIP CODE

3100 N TENAYA

NAME OF PROVIDER OR SUPPLIER  MOUNTAINVIEW HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE						
		3100 N TENAYA LAS VEGAS, NV 89128						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FI REGULATORY OR LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE			
S 035	Continued From page 1		S 035					
	Based on interview, record review and document review the emergency room medical staff failed to ensure a patient who was diagnosed with cholecystitis (inflammation of the gallbladder) and experiencing moderate to severe pain and nausea received an appropriate quality of care and was ordered and administered pain and nausea medication while in the emergency room. (Patient #1)							
	1. A facility emergency room physician failed provide a patient diagnosed with acute cholecystitis (inflammation of the gallbladde who was complaining of nausea, vomiting a moderate to severe abdominal pain with any orders for pain or nausea medication during hour emergency room stay.	r) nd /						
	Severity: 2 Scope: 1 Complaint # 22015							
S 050	NAC 449.314 Quality of Care		S 050					
	1. A hospital must be administered in a man that enables the hospital to use its resource effectively and efficiently to meet the needs and provide quality care to its patients. The governing body of a hospital shall develop a provide services for the care of its patients on the identified needs of those patients. This Regulation is not met as evidenced by Based on interview, record review and docu review the facility medical and nursing staff to provide quality care to an emergency roop patient diagnosed with cholecystitis (inflame gallbladder) by not providing the patient, who complaining of moderate to severe abdomin pain, nausea and vomiting with pain and nat medication during a 7 hour emergency room	s of  nd based : ment failed m d o was al						

PRINTED: 08/18/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVS640HOS** 08/14/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3100 N TENAYA **MOUNTAINVIEW HOSPITAL** LAS VEGAS. NV 89128 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S 050 Continued From page 2 S 050 (Patient #1) Severity: 2 Scope: 1 Complaint # 22015 S 300 NAC 449.3622 Appropriate Care of Patient S 300 1. Each patient must receive, and the hospital shall provide or arrange for, individualized care, treatment and rehabilitation based on the assessment of the patient that is appropriate to the needs of the patient and the severity of the disease, condition, impairment or disability from which the patient is suffering. This Regulation is not met as evidenced by: Based on interview, record review and document review the facility emergency room nursing staff failed to follow the facilities pain assessment policies and procedures and provide appropriate assessment, care and treatment to an emergency room patient diagnosed with cholecystitis. (inflammation of the gallbladder)

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

(Patient #1)

1. Nursing staff failed to follow facility policy and procedures and conduct hourly pain assessments

on a patient diagnosed with cholecystitis (inflammation of the gallbladder) who was complaining of moderate to severe abdominal

2. Nursing staff failed to notify the emergency room physician of the patients complaints of moderate to severe abdominal pain or obtain pain or nausea medication orders from the emergency

pain, nausea and vomiting.

PRINTED: 08/18/2009 FORM APPROVED

Bureau of Health Care Quality & Compliance

		(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMB		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		NVS640HOS		B. WING		08/1	14/2009	
MOUNTAINVIEW HOSPITAI		3100 N TEN	ET ADDRESS, CITY, STATE, ZIP CODE  IN TENAYA  VEGAS, NV 89128					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLE DATE		
S 300	Continued From page 3			S 300				
	room physician.							
	Severity: 2 Sc	ope: 1						
	Complaint # 22015							
S 310	NAC 449.3624 Assessment of Patient			S 310				
	at the time that the cathe patient must be a qualified hospital perpatient's contact with assessment must be accurate as related to.  This Regulation is not Based on interview, review the facility nur pain assessment policonduct and docume on an emergency roccholecystitis (inflamm who was complaining abdominal pain and results). Nursing staff failed hourly pain assessment patient diagnosed with	comprehensive and of the condition of the part as evidenced by eccord review and docursing staff failed to followay and procedures and not hourly pain assessment patient diagnosed whation of the gallbladder of moderate to severe nausea. (Patient #1)  I to conduct or documents on an emergency of the cholecystitis per facility	atient. : ment w I nents itth r) :					
	room physician of the moderate to severe a vomiting or obtain pa orders from the emer	I to notify the emergence patients complaints of abdominal pain, nausea in and nausea medicatingency room physician.	and					
	assessment, care an	d treatment of the patie ans orders for pain and	ent by					

PRINTED: 08/18/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS640HOS 08/14/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3100 N TENAYA **MOUNTAINVIEW HOSPITAL** LAS VEGAS, NV 89128 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S 310 Continued From page 4 S 310 nausea medication and not medicating the patient for complaints of pain and nausea. Severity: 2 Scope; 1 Complaint # 22015

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.